## *b.*—PATHOLOGY OF THE NERVOUS SYSTEM AND MIND; AND PATHOLOGICAL ANATOMY.

Ocular Symptoms in Diseases of the Central Nervous System.—The following are the principal conclusions of a recent memoir by Coingt (Paris, 1878) as abstracted in the *Centralblatt f. d. med. Wissensch.:*

Ptosis occurring by itself may depend upon an intra-cranial lesion, perhaps upon a direct implication of the third nerve or its nucleus. It commonly only affects the eye of the side opposite the hemisphere involved, where it occurs indicating cerebral involvement; and in an individual complaining of no other symptoms, the suggestion is of cerebral syphilis, or grey degeneration of the posterior columns of the cord, or chronic softening of the brain.

As regards the conjugate deviation of the eye and head, the author holds to the view of definite cerebral centres for these movements. Every excitation of one of these bilateral centres causes a conjugate movement toward the opposite side; every implication of their function has a conjugate movement toward the diseased side as a consequence. Both centres (for eye and head) are certainly very closely connected in the hemispheres, but can, nevertheless, be put into action independently. The symptom in question is observed in apoplexy, epilepsy and hysteria, and may be produced by slight as well as by serious brain lesions. It indicates (epileptic conditions excepted) a more or less serious cerebral alteration, which may be either multilocular or diffuse, unilateral or bilateral; but one side generally predominates. If the lesion is in the isthmus cerebri the deviation always occurs toward the side opposite the lesion. In lesions of the hemispheres the direction of the deviation varies: if there is hemiplegia, with or without contracture, but without special convulsions, the patient (according to Prevost) looks to the side of the lesion; are convulsions present, he looks away from the same side. But cases occur in which neither of these rules will apply.

As regards the condition of the pupil in lesions of the nerve centres, the author first notices the frequently observed inequality in general paralysis, the fact mentioned by Vincent, of its imperturbability to light. In unilateral injuries of the cervical cord the pupil is sometimes contracted, or the reverse, according to the predominance of irritative or paralytic conditions. Contraction of the pupil with coma is met with in ventricular hemorrhages, in hemorrhages of the pons, and especially in lesions of the middle brain; the pupil is sometimes narrower, sometimes wider, on the side of the lesion than on the other; most frequently, according to the author, the dilatation is on the side corresponding to the lesion.

In tabetic patients, contraction of the pupil with indifference to light is commonly observed, a combination that, according to Vincent, is not at all, or very rarely, observed in other forms of chronic myelitis.

Paralysis of the orbicularis oculi muscle is not commonly supposed to occur from cerebral cause in hemiplegia, but, according to the author, if one seeks to raise the lids of both eyes, the resistance is by far less on the paralyzed side than on the other; paralysis is therefore present, but is generally imperfect.

In conclusion, the author mentions the alternate hemiplegias, in which the limbs of one side and the oculo-motor and abducens of the other are paralyzed, which form of paralysis is well known, is characteristic of lesions of the pons.

In regard to conjugate paralysis of the abducens of the one, and of the internal rectus of the other side, the author only repeats the old Fereol-Foville observations.

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PARAPLEGIA IN SYPHILITIC SUBJECTS.—Dr. E. C. Seguin, *Archives of Dermatology*, April, furnishes an interesting paper on the subject of so-called syphilitic paraplegia, a title to which he objects, and gives the details of six cases. We extract his concluding remarks:

"These six cases (and I might have added others) suggest several lines of thought, which I shall briefly follow:

"Can we, at the present time, make a positive diagnosis of 'syphilitic paraplegia?' I think not; the diagnostic argument is fragile, and includes the fallacies of coincidence, interrupted sequence, and of unknown factors. Prominent among the reasons given for such a diagnosis is the one that the patient has had syphilis. This, in view of the complexity of the morbid conditions which cause paraplegia, and of the fact that symptoms are usually (in the nervous system) caused not by the nature but by the location of a lesion, is well-nigh worthless. Of more importance is a reasoning by exclusion, demonstrating that the paraplegia under consideration differs in notable particulars from that caused by well-known lesions of the spinal apparatus. I think that it may be learned from the cases related, and from those recorded in books and periodicals, that paraplegia of syphilitic origin is often atypical. In some of my patients pain in the back or in the side was severe, and suggested a lesion of the bones, or meninges. The co-existence of a cerebral lesion, as shown by palsy of the third or sixth nerve, or dementia, or recent epilepsy, would go far to establish the diagnosis. The age of the patient, adult life, is an aid.

"It is proposed to settle this obscure diagnosis by reference, *post hoc*, to the results of treatment. One objection to this is the logical objection that it throws the diagnosis out of the proper time; it carries it forward to a time when the patient will not want it much: *i. e.*, when cured or permanently paralyzed. Another objection is that it is far from proven that no other than syphilitic affections are cured or benefited by mercury and iodide of potassium.

"This last objection involves a question of so great medical and social importance, that I feel obliged to trespass a little longer on your patience to say a few words about it. It has happened to all of us, I dare say, to witness the cure of serious cerebral symptoms by the iodide of potassium in

persons who denied having had syphilis, and who bore none of the marks of the disease. I have seen at least five such cases, and in several of these there could be no question of the patient's truthfulness. The conclusions drawn from such a reasoning is usually that the affection treated was syphilitic; that the patient has deceived either himself or us as to infection.

"In the same way we are apt to argue about obscure symptoms which disappear under the use of quinine; they must be, they are malarial. There was a time when I accepted this argument as valid, but in the last two or three years a doubt has grown up in my mind, and acquired strength by added experience. This doubt is partly the result of clinical experience, and partly from an invincible objection to the doctrine of specifics.

"I have seen cases of disease which I cannot say were syphilitic, get well under iodide; and, on the other hand, I cannot be persuaded that this medicine or mercury acts specifically upon the syphilitic poison, be it in the shape of a dyscrasia or localized in solid tissues. These medicines, and others, cure disease, it seems to me, by changing and increasing the nutrition of the tissues, or by modifying the action of the nervous system, or by changing the chemical properties of the blood.

"The treatment of paraplegia which is supposed to be caused by syphilis, should be very energetic. The subject should, as soon as possible, be placed under the influence of mercury, by what method matters little. If the digestive organs are in good order I give the medicine by the mouth, guarded by opium, if necessary. The proto-iodide, the iodide, the two chlorides, and blue mass seem to be sufficiently good in proper doses. When there is no doubt as to the strength of the digestive organs, it is better to use inunctions of ungt. hydrargyri or of the oleates.

"This treatment alone may do good, but it is to be aided by the simultaneous use of the iodide of potassium, given according to the American method, viz., fearlessly in doses gradually raised from 2 grams to 24, or even 32 grams a day. When largely diluted, this seldom disturbs the stomach; much less often than most practitioners think.

"Important points in treatment of severe cases, are:

"1. To keep the bladder empty, and to prevent or reduce cystitis. This is to be done by removing the urine two or three times a day by means of perfectly smooth soft catheters, which are to be kept in carbolized water when not used. It is probable that some cases of cystitis arise by the introduction of bacteria into the bladder by dirty catheters. If cystitis exist, injections of lukewarm water, of borated or carbolized water, will do good, or even cure the disease.

"2. To prevent bed-sores, by keeping the sheets and shirt of the patient perfectly smooth and taut; by preventing urine from running under him; by frequent sponging with alcohol and water, and by the use of powders. If bed-sores have formed, they should be treated by ice or snow poultices for ten minutes twice a day, and stimulating dressings during the rest of the time; all gangrened shreds should be picked out, and the recesses of the sore injected with strongly carbolized water. Pressure should be removed by change of posture and by appropriate pads.

"In the stage of recovery the iodide of potassium may be employed in moderate doses, continuously or intermittingly.

"An occasional week of mercurial may also be of benefit. Tonics are often called for, and among the best is cod-liver oil.

"The muscles may need massage or electricity. The patient should be made to sit up in a chair, and try to walk as soon as possible."

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THE LOCALIZATION OF BRAIN DISEASE.—Prof. Henoch, in *Charitè Annalen*, fourth year, reports nine cases of tuberculosis of the brain, that show how risky it is to localize, basing this upon recent physiological investigations. The results are as follows:

| SYMPTOMS. | LESION. |
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| CASE I.—Left hemiplegia. | Multiple tubercles of the cortical layer of both hemispheres, the frontal lobes and tubercle of the left half of the cerebellum. |
| CASE II.—Tremor and paresis of the right side, finally, contraction of all extremities. | Tubercle of the left frontal lobe, the left corpus striatum, both thalami and right half of the cerebellum. |
| CASE III.—Hemiplegia and contracture of the left side, as well as of the facial nerve. | Tuberculosis of the right frontal lobe. |
| CASE IV.—Contracture and involuntary motion on right half of face and body. | Tuberculosis of the left frontal lobe. |
| CASE V.—Complete absence of symptoms until meningitis set in. | Tuberculosis of the commissure of the cerebellum and of both hemispheres. |
| CASE VI.—Paralysis of the left abducens, the left iris and right arm. | Tuberculosis of the commissure of the cerebellum. |
| CASE VII.—Absence until meningitis set in. | Tubercle in the pons. |
| CASE VIII.—Complete absence. | Tubercle of the left posterior lobe. |
| CASE IX.—Paralysis of the right abducens. | Tuberculosis of both posterior lobes, the posterior corpora quadrigemina, the pons and left crus cerebelli. |

Of all these cases only II. and III. show the possibility that lesions of the motoric centre of the frontal convolutions produce motoric lesions of the opposite side. This chance of diagnosis, however, is very limited, as is shown by the other cases where these locations were free from disease, and yet the same symptoms produced with lesions in other parts of the brain, even cerebellum (Case VI.). Sometimes the intensity of the symptoms does not seem to correspond with the intensity of the lesion (V. and VI.). Henoch believes that a close study of the fibres leading from and to these physiological centres will do much to reconcile the apparent contradictions between pathological and symptomatological differences.—*Lancet and Clinic*, May 31.

Influence of Age, Sex and Marriage on the Liability to Insanity.—In the *Journal of Mental Science*, for April, Dr. T. Algernon Chapman, from a detailed analysis of the statistics in the Report of the Commissioners in Lunacy, comes to the following conclusions:

1. These tables deal with sufficiently large numbers to give satisfactory results.

2. The numbers sent to asylums increase up to thirty-five years of age, when twelve per 10,000 living are annually sent; thereafter the number diminishes steadily to ten per 10,000 in old age. That if the age on first attack were given, instead of age on admission, and those always more or less congenitally defective were tabulated separately, the result would show a remarkably uniform proclivity to insanity throughout life, from thirty upwards, if not from twenty.

3. Insanity affects males more largely than females, from 20–40; again slightly more from 60 upwards; from 40–60, females are slightly prone. If general paralysis be treated separately, then females are much more affected from 40–60; at other ages there is an equality.

4. 3.5 per cent (1 in 30) of those who attain the age of 20 ultimately become inmates of asylums.

5. The single are sent to asylums in proportion greater than married, as 2.83–1; the widowed as 3–2, *i. e.*, in proportion to the numbers of each in the general population above 20 years of age, though the actual numbers of single and married admissions are nearly identical.

6. It is almost certain that in the excess of single above married, the excess is due, not to celibacy causing insanity, but to insanity or a tendency thereto preventing marriage. If this be so, about one per cent. of the single among the general population, aged 20–30, and about three per cent. of those aged 30–40, are so from mental defect ultimately causing their admission to an asylum.

7. General paralysis is more frequent among males than females; but at the age 40–50, when the disease is most frequent, this relative frequency is least marked.

8. Unlike insanity in the mass, general paralysis is hardly more frequent in the single than in the married, a circumstance probably traceable to the comparative rarity of congenital defect in general paralytics.

9. General paralysis results much more frequently than ordinary insanity from causes implying business energy, and the use (and abuse) of the activities of life; much less frequently from defects inherent in the individual.

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Spastic Spinal Paralysis (Erb); Tabes Spasmodica (Charcot).—In a paper read before the Berlin Medical Society and published in the *Berliner klinische Wochenschrift* for December 2d and 9th, 1878, Dr. Leyden says that he has observed a number of cases of which the clinical history, the necropsy, and the microscopic examination have been recorded, and which during life presented the symptoms of spastic paralysis. One case at a certain period of the disease presented strongly marked extension contracture and rigidity; but, later on as in the other case, there was flexion-

contracture. All these cases, however, which had a fatal termination, presented also a high degree of paraplegia, partly associated with secondary atrophy of the paralyzed muscles, partly with disorders of sensation and of the bladder. *Post-mortem* examination showed chronic myelitis of various form and extent, affecting the dorsal portion, either alone or in conjunction with other parts of the spinal cord. He has also seen the symptoms of spastic paralysis presented in a number of other cases which did not end fatally, but in many of which an accurate anatomical diagnosis could be made. He classifies these cases under the following divisions:

1. Traumatic myelitis, in the later stages of which muscular spasms and contractures often occur. 2. Myelitis from compression of the spinal cord by carious vertebræ or by tumors. 3. Spontaneous myelitis. 4. Spinal paralysis, following acute disease, of which he has seen examples of the spastic form following typhus, small pox, and relapsing and intermittent fevers; in this category he also places puerperal paralysis. 5. Syphilitic paralysis, which, according to his observations, very commonly takes the form of spastic paraplegia; and 6, certain cases where the disease runs an acute or a subacute course, and extends upwards over the whole of the spinal cord. They may with great probability be regarded as meningitis or perimyelitis, and have a tendency to end in recovery. Dr. Leyden sums up his remarks in the following conclusions:

1. Spastic paralysis (characterized by rigidity of the muscles, muscular spasms, spinal epilepsy, increased tendon-reflex, extension and flexion-contractures) is a pretty frequent symptom in various diseases of the spinal cord; but it indicates no special form of disease. 2. It occurs in acute and subacute affections of the spinal cord, and in these circumstances is capable of perfect recovery. Cases of this kind are partly diffused (ascending) meningitis and perimyelitis (myelo-meningitis), partly circumscribed perimyelitis. 3. In acute myelitis (spontaneous, traumatic, or from compression), the symptom is, as a rule, not developed in the first stages of the disease, but very commonly appears in the second or chronic stage. In the same way, it is frequent in cases of myelitis with long-continued compression of the spinal cord. 4. The spastic form of paralysis is most frequently observed in chronic myelitis (sclerosis) when this occurs in one or more foci, one of which usually lies between the cervical and lumbar enlargements. In these cases, the periphery of the white anterior and lateral columns is more or less affected; there is, therefore, a varying extent of (chronic) leucomyelitis or myelo-meningitis. A special limitation of the sclerosis to the lateral columns has not yet been observed. 5. If it were desired to describe as a special form of disease those cases of chronic myelitis which are very slowly developed and remain free from disturbances of sensation and from paralysis of the bladder, they would correspond to the condition designated spasmodic tabes. But the expression "tabes," as Erb has correctly remarked, is applied in German literature to degeneration of the posterior columns; and the contrast of tabes atactica and tabes spasmodica would only be of importance, if the latter depended on a systematic sclerosis of the columns of the cord. In spite, however, of the remarkable symptoms these cases present no special type of disease either in anatomy or in symptoms. Ana-

tomically, they belong to chronic myelitis (leucomyelitis), the symptoms of which vary according to its stage and extent; symptomatically, neither the general commencement nor the absence of perceptible symptoms, is characteristic; for we see the same processes, at least the same anatomical lesions, after acute commencement, after repeated exacerbations, and when the course of the disease has been progressive. The absence of disturbance of sensation is accidental, and depends on the situation and extent of the focus of the disease Finally, in further progress of the case, the spastic symptoms may again disappear.—*British Medical Journal*, March 15, 1879.

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The Condition of the Muscles in Paralysis.—In the paper above referred to, Dr. Leyden says, that spinal paralysis (and also cerebral and peripheral paralysis) may be divided into two great groups, according to the condition of the paralyzed muscles: *a*. Those in which the muscles are flabby, have lost their tonicity, and can be easily moved in all directions, so that the position of the limbs depends simply on gravitation; *b*. Those in which the tonicity of the muscles remains normal, and, as a rule, even increased, so that they have a tendency to contract and shorten and to oppose a tenacious resistance to extension. The first form occurs under conditions which diminish the tonus; the second under those which increase it. If we now concede to the sensory (or centripetal) nerve fibres an important influence over the muscular tonus, which we are justified in doing by the researches of L. Hermann and Cohnheim, and by Cyon's experiments on the influence of the posterior roots on irritability, the pathological facts become capable of a satisfactory explanation. Atonic paralysis is observed in the following conditions: 1. In extensive atrophy of the sensory fibres (posterior columns and nerve roots), in progressive locomotor ataxy. To this point Dr. Leyden has already directed attention in a monograph, published in 1863. In tabes dorsalis the muscles are flabby and atonic; but this does not exclude the possibility of the occasional occurrence of atonic condition. 2. Diseases of the grey matter interrupt the connection between the anterior and posterior roots by atrophy of the ganglion cells, without injuring sensation itself. It is hence conceivable that atrophic paralyses, proceeding from intense atrophy of the grey matter, belong to the atonic class. Slight diseases of the grey matter, especially of the interstitial tissue, are not unfrequently accompanied by a tonic condition of the muscles. 3. In cases where the irritability of the spinal cord, especially of the grey matter, is much diminished, atonic paralyses also occur. This is the case in the commencement of myelitic, and especially of traumatic affections of the portions of the spinal cord. Here we assume, with Goltz, an arrest of the function of the cord lying below the lesion, so that the reflex action is destroyed or greatly impaired, as also is the tonus of the muscles. This is the case in the last stage of severe diseases of the spinal cord, where the irritability, one might say the vitality, of the portion of muscle lying below the lesions, is destroyed, with, as a rule, general loss of strength. We here see atonic muscular paralysis appear, where, perhaps, distinct tonic paralysis has been present. This fact has not escaped the notice of Charcot, who says, that spastic symptoms may disappear towards the end of the case.

On the other hand, tonic or spastic muscular paralysis occurs under conditions which raise the reflex influence of the sensory fibres. This may occur: 1. From increased irritability of the motor fibres—neurotic peripheral paralysis. 2. From increased irritation of the sensory roots—neuritic or meningitic process. 3. From partial or complete interruption of the conduction of the will from the brain, the conduction of reflex impressions through the grey matter being preserved or even increased. Especially at the time when neuritic processes, often accompanied with much pain, are developed in the paralyzed limbs, muscular spasms and contractures begin to appear. What share the descending degeneration of the lateral columns has in this seems as yet doubtful. The condition is the same where there are myelitic foci, which intercept the conduction of the will from the brain, but leave intact the conveyance of reflex action through the grey matter (leucomyelitis).—*British Medical Journal*, March 15, 1879.

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Neuritis Migrans.—L. Putzel, M. D., *N. Y. Med. Record*, April 26, reports a case of neuritis of the internal cutaneous, external cutaneous, and ulnar nerves, from extension of inflammation from a boil over the right olecranon process. The neuritis extended upward along the ulnar nerve into the axilla and brachial plexus, being felt as a thick, indurated cord. Downwards it extended to the hand, causing paralysis of ulnar side of hand with anæsthesia and trophic changes. Evidences of inflammation also appeared in the auricularis magnus, producing redness of the tip of the ear and of a patch on the side of the neck, with anæsthesia. A similar patch also made its appearance below the inferior angle of the right scapula. Later in the disease, another similar patch appeared in the middle of the thigh anteriorly, and about six inches below Poupart's ligament; and still another over the left deltoid. The patient gradually improved under treatment and was lost sight of. All these, Dr. Putzel refers to the original neuritic trouble, and considers the case as clinically supporting the theory of neuritis migrans. The inflammation spread upwards along the ulnar nerve to the cord, producing there some medullary lesion, and then appeared again in the peripheral nerves (auricular, etc.). Just what this medullary lesion was cannot be told; it may have been a chronic disseminated myelitis, or the meninges alone may have been affected. The case though purely clinical is one of interest.

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Reflex Inflammations.—Under this head have been described certain inflammations occurring at a distance, following a prolonged irritation of some part of the body, sometimes in a corresponding symmetrical locality, and always in a region innervated from the same region of the cord; it is in this manner that we explain sympathetic ophthalmia, and visceral lesions following extensive cutaneous burns, etc MM. Hallopeau and Neumann report in the *Gazette Médicale*, a case of inflammation explainable according to this theory. In a man troubled with rather indefinite thoracic pains, they applied two blisters successively to the same point, between the left

border of the sternum and the nipple. There followed a severe pain with cutaneous inflammation involving the left nipple. These symptoms rapidly disappeared and the pain reappeared directly in the right breast, where there soon appeared pimples formed by the sebaceous glands of the part, many of these taking on the aspect of small boils; the whole breast became indurated, red, and painful, and from which abscesses formed, after opening which the whole inflammation disappeared. The authors consider this a case of reflex inflammation, it being produced not by propagation, as was easily seen, nor by mere coincidence, inflammations of the breast being exceedingly rare in the male. It may be said that the process seemed as if the irritation of the nerves appertaining to the left nipple and areola was transmitted to the spinal centre, and thence to the nucleus of origin of the nerves of the right areola, and through them provoked an irritation in that region. This is the mechanism called in by M. Vulpian to explain, in a general way, the production of reflex inflammations.—*Journal de Medicine et de Chirurgie Pratiques*, April.

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Mysophobia.—At the meeting of the New York Neurological Society, April 7 (rep. in *N. Y. Medical Record*), Dr. W. A. Hammond read a paper upon the above subject, in which he described a form of mental derangement that consisted in a *fear of defilement or contamination.*

Ten cases had fallen under his observation, but not fully recognizing the exact nature of the earlier ones, he based his paper upon the complete clinical histories of the last three. In the first case described there was an overpowering desire to wash the hands, and in that occupation the patient spent a large share of her time. The fear of becoming contaminated gave her the most intense mental anxiety, suffering and distress; and although she was able to recognize the absurdity in her case, yet during her waking hours she was haunted and followed by what was to her a most terribly distressing fear.

In the second case the fear of pollution was more extended and serious, and the patient washed her hands as many as two hundred times a day.

The third case was equally well defined, but not so severe. When the patient visited the doctor's office she could not be induced to touch the door-knob when she was ready to leave the consultation-room, because of the tormenting and distressing fear of becoming contaminated, which held her in complete possession. The treatment which he had exhibited had been to keep the bowels quite soluble by means of pills composed of podophyllin, aloes, and ox-gall; to administer bromide of potassium, sodium, or calcium, and in combination with opium if there was a tendency to melancholia; and to use tonics—such as cod-liver oil, strychnia, iron, and quinine.

Dr. E. C. Seguin referred to a case in which the patient suffered through fear of croton bugs. The fear followed her, and she saw the bugs, when it was well established that there were none present. She was cured by moral treatment and by tonics.

Dr. Spitzka spoke of mysophobia as a symptom which complicated different conditions, and

Dr. KIERNAN mentioned cases of chronic mania in which he had seen similar symptoms.

Dr. HAMMOND remarked that the cases which he had reported, and to which he referred, were not cases of insanity, for they had neither hallucinations nor delusions.

This paper was subsequently published in full in Neurological Contributions.

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ALCOHOLISM OF PARENTS AS A CAUSE OF EPILEPSY IN THEIR CHILDREN. —Dr. Hippolyte Martin, *Ann. Méd. Psychol.*, Jan., gives an account of the investigations made by himself on the influence of intemperate habits of parents on their offspring as regards the production of epilepsy, while *interne* at the Salpêtrière. Out of one hundred and thirty to one hundred and fifty patients in the department for insane epileptics of that institution, he was able to obtain data as to heredity in eighty-three. Twelve of these cases are briefly detailed and an analysis of the whole is given. He divides them into two classes: in the first, comprising sixty patients or over two-thirds of the whole, intemperate habits in the parents was an established certainty; in the second class of these patients, the intemperance of the parents was dubious in some, and in others could not be suspected. The sixty of the first class had had two hundred and forty-four brothers and sisters; of this number forty-eight were affected with convulsions from early infancy, one hundred and thirty-two were dead in 1874, and one hundred and twelve only were still living, nearly all young and many of them with damaged nervous organizations.

The twenty-three epileptics of the second class had had eighty-three brothers and sisters, among whom only ten had had convulsions, and forty-six were still living. In these figures, of course, the patients themselves are not included. Of these eighty-three epileptics, all from different families, the particulars as to the origin of the disease could be obtained in seventy-eight, and it was found that fifty of them had first had eclamptic convulsions quite distinct from epilepsy. Thus in eighty-three families there had been four hundred and ten children. One hundred and eight of these, that is, more than one-fourth, had had convulsions; in 1874, one hundred and sixty-nine were dead, and two hundred and forty-one living, but of these latter, eighty-three, or more than a third, were epileptic.

In looking up the diseases of the parents and grandparents of these patients, the records of the following diseases were obtained:

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|---|---|
| Apoplexy | 15 |
| Heart Disease | 5 |
| Thoracic Disease | 6 |
| Suicides | 4 |
| Hysteria | 5 |
| Mental Alienation and Dementia | 4 |
| Cancer | 7 |
| Dropsy (?) | 1 |
| Chagrin (?) | 1 |

It is not stated, but it is probable that the cause of death is here given in most but of course not all of these cases. The author remarks on the small proportion of diseases of the nervous system in the above, and hence concludes that to alcoholism alone must be attributed the epilepsy of the children. The large proportion of circulatory disorders (including under this apoplexy and heart troubles) which are directly favored by intemperance is also a striking fact. He concludes as follows: "We have therefore demonstrated that alcoholism in the ancestors is an extraordinarily frequent cause of eclampsia and epilepsy in their descendants; and if, as we have said in a former article, epileptics have only few children, and further, that these are almost inevitably affected by the most serious nervous disorders, we perceive what formidable evils alcoholism of the parents transmits to their posterity.

"Alcoholism is therefore the brutalization of the drinker and a miserable existence and speedy extinction of his posterity. This sombre picture may serve as an example to the unhappy victims of the appetite, and should, at all events, sustain the zeal and devotion of those who are striving to reform those beings whose degradation is at once a shame and a peril to the human species."

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Pathology of Tetanus and Hydrophobia.—At the meeting of the Pathological Society of London, April 29 (rep. in *British Medical Journal*), Dr. Ross showed microscopical sections illustrative of the pathology of the nervous system in hydrophobia and tetanus. He met with: 1, vascular engorgement along with evidences of effusion of a granular material and migration of leucocytes, described previously by Allbutt, Lockhart Clarke, Dickinson, Benedikt, and Gowers; 2, the yellow degeneration of the ganglion cells described by Allbutt; 3, in two cases of tetanus and two of hydrophobia, a large number of colloid bodies, and what appeared to be the condition described by Dr. Batty Tuke and by Mr. Kesteven as "miliary sclerosis." As, however, these cords were partially hardened in spirit, Dr. Ross was doubtful how far they might be regarded as evidences of disease, and he spoke with especial reserve as regarded the importance to be attached to the presence of colloid bodies. The most marked evidences of disease in the cord were found on each side of the central canal; but the posterior and anterior horns were affected. In tetanus, the vesicular column of Clarke was always injured, often completely destroyed; and it was also injured, but to a less extent, in hydrophobia. A distended vessel was generally observed to pass between the median and antero-lateral groups of ganglion cells of the anterior horns; and the ganglion cells on each side were destroyed, the destruction of cells being usually greater in tetanus than in hydrophobia, but never wanting. A similarly distended vessel was frequently observed passing through the postero-lateral groups, the destruction of ganglion cells here being usually more marked in hydrophobia than in tetanus.

In the inferior portion of the hypoglossal and spinal accessory nuclei, the cells were found nearly destroyed in tetanus; those of the hypoglossal

were less so in hydrophobia; but the damage to the spinal accessory and vagus nuclei was much greater in hydrophobia than in tetanus. The condition of the medulla in hydrophobia corresponded closely to that described by Dr. Gowers. In two cases of tetanus, vascular changes and colloid bodies were found in the cortex and adjoining white substance of the cerebellum. In hydrophobia, colloid bodies, vascular changes, and at times yellow degeneration of the large cells of the fourth layer of the cortex, were observed. The condition described as miliary sclerosis was observed in two cases of hydrophobia. In the cord, the patches occupied the posterior and antero-lateral columns. Beyond the cord, the patches were observed in the anterior pyramids of the medulla and in their continuation through the pons varolii, middle third of the crusta, and middle third of the internal capsule. Similar patches were observed in the formatio reticularis and in the portion of the pons which corresponds to the anterior root-zones of the cord, and also in the parts of the corpus striatum adjoining the internal capsule. The state of the cord and medulla appeared, on the whole, to be very much the same in the two diseases, and the differences in the symptoms might perhaps be due to the fact that in tetanus the morbid changes were directed more to the cerebellum, while in hydrophobia the cerebrum was more affected.—Dr. Frederick Taylor said that he thought the presence of colloid bodies a very untrustworthy sign of disease, because they appeared to be produced by *post-mortem* changes in the cord. It was not possible to say exactly under what conditions they were developed, possibly by the action of spirit on cords in a certain stage of decomposition. Mr. Golding-Bird mentioned a case of chronic tetanus which had begun acutely, where the cord was found to be perfectly healthy in all parts. Dr. Ross, in reply, said that, though he did not wish to attach too much importance to the presence of colloid bodies, yet he could not altogether agree that they were always the result of *post-mortem* changes. He had seen them in cords which had been in neither spirit nor chromic acid. They were certainly not the result of changes in myeline matter, because he had found them in specimens of cheesy pneumonia.

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Paralysis of the Serratus Magnus in Infantile Paralysis.—At the meeting of the Clinical Society of London, May 23 (rep. in *Brit. Med. Journal*, June 7), Dr. D. B. Lees read notes of two cases of infantile paralysis which presented some peculiar features. We copy the report in the *British Med. Journal:*

Elizabeth M. was sent to the hospital for sick children; the muscles in worst condition were those of the left shoulder and right leg: In most of the muscles of these limbs faradic response was absent, and in many of the muscles of the left leg, and also in the right deltoid, it was much impaired. After the child had been brought to the hospital for a few weeks, it was noticed that there was marked falling in of the left side of the front of the chest during inspiration, instead of the normal expansion. The position of the left scapula was found to be altered; it was drawn up to a higher level than the right scapula, the upper angle was drawn nearer to the spinal

column, and the lower angle had left the chest-wall and projected backwards. These symptoms seemed to justify a diagnosis of paralysis of the serratus magnus. On applying the electrodes of a battery over this muscle, a forward movement of the scapula at once responded to a current from seventeen Leclanchè cells on the right side, but no movement could be obtained by the use of a much stronger current on the left. It was possible that in this case the interossei were also paralyzed, and certainly the rhomboidei had suffered, there being no muscular resistance when the scapula was pulled forwards. The child's general condition had since improved, but the position of the scapula and the electrical reactions were nearly unaltered. Herbert P., aged twelve months, was found completely paralyzed one morning early in December, 1878. When brought to the Hospital for Sick Children on December 20th, it was found that in him also the parts most deeply affected were the left shoulder and arm and the right leg. The right deltoid was decidedly paralyzed. It was observed that the angle of the left scapula projected from the chest-wall. On turning the child on his back, the left scapula fell away from the ribs. It was doubtful whether a less degree of a similar condition was not present on the right side also. Respiration was entirely diaphragmatic. There was no unilateral depression of the thoracic wall during inspiration. No response to electricity could be obtained in either serratus. This child had considerably improved under treatment. The right scapula was now in normal position, and the left nearly so. Some response to faradism had reappeared in both serrati and both deltoids had regained much power. He could now raise the hand above the level of the shoulder on the right side, but was still unable to do so on the left. In both these cases the serratus was only one of many muscles paralyzed, but the signs of its affection were distinct. Paralysis of this muscle was a rare condition, and Dr. Lees was not aware that attention had been previously drawn to it as an occasional complication of infantile paralysis.

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JUVENILE INSANITY.—At the meeting of the Medical Society of Pennsylvania at Chester, May 21 (rep. in *N. Y. Med. Record*), Dr. I. N. Kerlin, Superintendent of the Home for Feeble-Minded Children, at Media, read a paper with the above title. Mental disease, he said, was more frequent in childhood than was commonly imagined. According to the statistics of Dr. Bourteville, the proportion of insane children, between the ages of five and nine years, was 10 per cent.; between ten and fourteen years, 35 per cent.; and between fifteen and nineteen years, 20 per cent. It was not improbable that many of the minor forms of juvenile insanity were allowed to go unrecognized, being regarded as a temporary consequence of sympathetic disturbance, or the sequel of acute disease, and so likely to pass away when the cause was removed, or overgrown. In many cases that happy sequence did not occur, and the little victims sank rapidly into the dementia of idiocy, or developed into erratic, excitable, vicious childhood, passing through the courts, and the refuges and the reformatories as criminals, from whence they graduated into other planes of crime.

REMISSIONS IN PRIMARY PARALYTIC DEMENTIA.—The following are the conclusions of a lengthy article by Baillarger in the *Annales Med. Psychologiques*, January, on remissions and dementia in certain cases of general paralysis, in which he analyzes some ten observations from various sources.

1. Melancholia with paralytic stupor or simple paralytic stupor may take on the most serious symptoms and simulate an advanced dementia, and nevertheless be followed, even after many months, by remarkable remissions.

2. When the symptoms of dementia, with some delirious ideas, develop rapidly, in the first period of general paralysis, they do not appertain to a genuine dementia, but to a *pseudo-dementia*, constituting a special condition not yet sufficiently studied.

3. It is often wrongly assumed that dementia exists from the beginning of general paralysis from certain special symptoms, or it is presumed to be masked by the maniacal or melancholic delirium.

4. The mobile, absurd and contradictory delirium of paralytics, is no proof of the existence of dementia, and may be explained by a special condition comparable to certain cases of intoxication.

5. The *pseudo-dementia* in general paralysis cannot as yet be distinguished from veritable dementia except by its rapid invasion or by signs of stupor.

6. There are no true remissions in the simple, slow and progressive paralytic dementia.

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The following are the titles of some of the recently published papers on the Pathology of the Nervous System and Mind and Pathological Anatomy:

STILLMAN, Neurasthenia, *Med. and Surg. Rep.*, May 17.—THOMSON, on Astigmatism as a Cause for Persistent Headache and other Nervous Symptoms, *Med. News and Libr.*, June.—BEARD, Nervous Diseases Connected with the Male Genital Function, *N. Y. Med. Record*, June 14.—HAMILTON, On Epilepsy, *Ibid*, June 7.—MITCHELL, Spasmodic Disorders of Legs, *Ibid*, June 28.—BARTON, Dipsomania, Its Medical and Legal Aspects, *Practitioner*, June.—LAUDER-LINDSAY, Spurious Hydrophobia in the Lower Animals, *Edinb. Med. Journal*, June and July.—CLOUSTON, The Study of Mental Disease, *Ibid*, July.—BUMSTEAD, Sexual Hypochondriasis, *Am. Practitioner*, July.—GRAY, Cerebral Syphilis, *Proc. Med. Soc. Kings Co.*, July.—WRIGHT, Some Points Connected with the Question of Responsibility as it Relates to the Partially Insane, *Lancet and Clinic*, July 12.—MANN, The Psychological Nature and Significance of General Paralysis and its Pathology, *Detroit Lancet*, July.—NACKE, Delirium Tremens, *Centralbl. f. d. med. Wissensch.*, No. 25.—ROSENBACH, The Diagnostic Significance of the Reflexes, particularly the Abdominal Reflexes, *Centralbl. f. Nervenheilk.*, May 1.

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